

# State of Maryland

REQUEST FOR REIMBURSEMENT FOR NON-MEDICAID OUTPATIENT SERVICES 11/15/2009

(Form to be sent by CSA to ValueOptions if approved)

<b>FOR PROVIDER USE ONLY:</b>			
Value Option (VO) Provider Number:		Provider Name:	
Provider Contact Name:		Provider Phone Number:	_____
Provider Fax Number:	_____	Provider Email Address:	_____
<b>CONSUMER INFORMATION:</b>			
Registration Date:	_____	Consumer or Medicaid ID:	_____
Last Name: _____	First Name: _____	Middle Initial:	Suffix:
Gender:	<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> UNK		
Date of Birth: _____/_____/_____	SSN: _____	<input type="checkbox"/> No SSN <input type="checkbox"/> Unknown SSN	
Primary Address:	Street:		
	City:		
	State:		
	Zip:		
	County:		
	Phone: _____		
<b>FOR CSA USE ONLY:</b>			
<input type="checkbox"/> Approved <input type="checkbox"/> Denied			
Reason for Exception or Denial:	_____ _____ _____		
CSA Name:			
CSA Phone Number:	CSA Fax Number:	CSA Email:	
Comments:	_____ _____ _____		
<b>FOR VALUEOPTIONS USE ONLY:</b>			
Consumer ID:			
Comments:			